



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INJURY – 1 TREATMENT CENTER
5931 DESCO DR
DALLAS TX 75225

Respondent Name

ULLICO CASUALTY CO

Carrier's Austin Representative Box

Box Number: 48

MFDR Tracking Number

M4-12-0798-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "no preauth required w/evaluation treatment was preauthorized."

Amount in Dispute: \$\$365.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier, or its agent, did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2011	CPT Code 90801	\$ 229.63	\$0.00
March 3, 2011	CPT Code 90806	\$135.47	\$135.47

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).
4. The service in dispute for January 10, 2011 was denied using denial code "50 – These are non covered services because this is not deemed a medical necessity by the payer."
5. The service in dispute for March 3, 2011 was denied using denial code "216 – Based on findings of a review organization."

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on November 7, 2011. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue of medical necessity have been resolved as of the undersigned date for date of service January 10, 2011.
2. The requestor has supported that the treatment provided for date of service March 3, 2011 is eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307. In accordance with Texas Administrative Code §134.600(c)(1)(B) The carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) or (q) of this section only when the following situations occur: preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing health care. The requestor submitted documentation supporting that preauthorization was given for date of service March 3, 2011. Therefore, denial reason "216" is not supported.

Conclusion

For the reasons stated above in paragraph one, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment for date of service January 10, 2011. As a result, no amount is ordered.

For the reason stated above in paragraph two, the requestor has established that the respondent's denial of payment reason concerning medical necessity for date of service March 3, 2011 was not supported. As a result, the amount ordered is \$135.47.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$135.47 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Marguerite Foster
Medical Fee Dispute Resolution Officer

December 12, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.